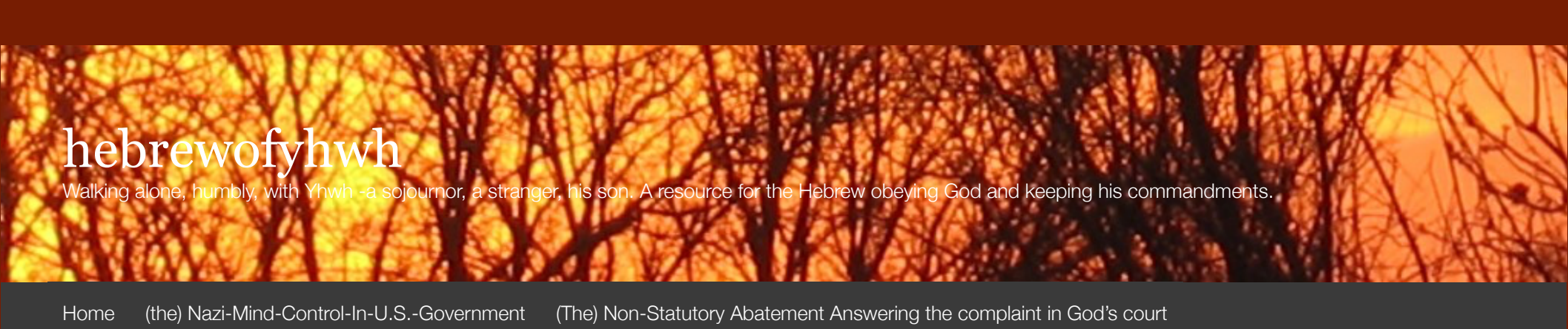

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Nature’s Healer (For educational and entertainment purposes only)

“DMSO – NATURE’S HEALER” by Morton Walker, M.D.

The American Medical Association (AMA) held a leadership conference the weekend of February 14, 1981, and one of its speakers was Otis R. Bowen, M.D. Dr. Brown is former governor of Indiana, a leader in medicine, management, and politics. In his presentation to the AMA, he shocked the assembly by admitting that he took the law into his own hands and used an illegal drug to ease his wife’s pain when she was dying. Beth Bowen died January 1, 1981, after months of agony from multiple myeloma, a type of bone cancer.

Dr. Bowen, who was preparing to step down from the governorship at the time, turned to dimethyl sulfoxide, or DMSO, to ease his wife’s intense pain. He had obtained the liquid solvent from a veterinarian and found that it relieved his wife’s suffering “in minutes,” he said.

The Food and Drug administration (FDA) forbids the use of DMSO in humans except in treating a rare urinary bladder condition. Even in the face of the government ban, Dr.; Brown did what he knew was right for his wife by administering intravenous DMSO. “Why can’t dying persons, with severe pain, have easy prescription access to it?” He asked in his speech. “The only excuse I could find was that, after prolonged use and heavy dosage, it caused an occasional cataract in dogs only.”

Before you’ve read very far into this book, you’ll probably be asking questions similar to Dr. Bowen’s. It won’t be difficult to identify with the patients involved here, some of whom have been forced to take treatment into their own hands by turning to DMSO.

In fact, DMSO has not been found unsafe for humans. Any side effects are merely minor irritations. DMSO stops bacterial growth. It relieves pain. As a vasodilator, the drug enlarges small blood vessels, increasing the circulation to an area. It softens scar tissue and soothes burns. DMSO’s anti-inflammatory activity relieves the swelling and inflammation of arthritis, bursitis, tendinitis, and other musculoskeletal injuries. And it does many more good things of a therapeutic nature for anyone who is injured or ill.

I recommend that you use DMSO strictly under the supervision of a doctor who is skilled in its application. Only the pure pharmaceutical grade should be employed, not the crude industrial grade.

DMSO is both a drug and a good solvent. Industry values it for removing paints and varnishes, and dissolving certain plastics such as rayon, polyvinyl chloride, polyurethane, methacrylate, and acrylic. It doesn’t affect cotton, wool, nylon, leather, or polyesters.

Most important, it benefits human body cells, tissues, and organs in unique ways. DMSO is the twenty-first century’s newest healing principle with a very wide range of usefulness. It represents an entirely different means of treating diseases – not as an ordinary drug works for a given disease, but as a holistic ingredient that brings whole-body cellular function back to normal.

Dimethyl sulfoxide has had a bettered thirty-year history. But because of the general public outcry about its ban, DMSO has become a household word and a medical-political cause célèbre. Those of us who have been using the drug for twenty-six to twenty-eight years never dreamed that it would become a focal point in the continuing battle between individual freedom and the power of government

My colleagues and I have been criticized, ridiculed, and even persecuted in some medical circ les for promoting and using DMSO. But I, and others like me, came to the conclusion, having observed establishment medical thinking for forty years that the only way a truly revolutionary treatment principle can be brought to the patient is by appealing to the general population through the information media. That is the purpose of this book.

Much of my material will appear anecdotal to the scientist, but such language is what the public understands best. And sometimes a hundred patient stories, heard by a sensitive and intelligent physician, are as good as or better than a double-blind research project. Double-blind studies are often just that – everyone involved is blind and stays that way until, many years later and thousands of patients later, it is discovered that the particular drug doesn’t work or is too toxic to warrant its use.

Good examples of toxic drugs are the arthritis agents Motrin, Tolectin Nalfon and Naprosyn. They all underwent extensive double-blind testing. All are weak organic acids and prostaglandin inhibitors – like aspirin. About as effective as aspirin, these four drugs have two distinct differences: they are more toxic than aspirin and cost ten to thirty times more money. So much for double-blind studies.

Whether you agree or disagree with current claims, it’s likely you’ll affirm that if a drug has been proven safe, doctors should be free to use this agent when they believe it will help their patients. With all the extremely potent and dangerous drugs on the market, it is absurd to keep such an effective product as DMSO from pharmacy shelves.

Certainly not all of the claims for DMSO will prove to be valid, but in my opinion, many of them have already shown themselves to be true. And the most dramatic use of the medication is likely yet to be discovered.

Another purpose for my book is to point out the myriad applications of this unique substance. Once DMSO is legalized for use in all states and ethically produced for topical, parenteral, and oral administration, people won’t have to smuggle the feed-store grade and the crude industrial grade into their homes to paint on their arthritic joints.

DMSO will eventually find its place in the armamentarium of American medicine. We who believe in the substance want to see it happen sooner than later. The clinical evaluation of DMSO began in the United States in 1963 and now, in 1992, the FDA still has not approved the drug for more than one use. This situation gives rise to some underlying questions you may find running throughout this book. How do we get the FDA to see beyond its blind spot? How can we either bring DMSO to the people or declare the substance useless once and for all?

You will find lots of answers in these pages. DMSO needs even more public pressure than has been leveled at the regulatory process already. We want doctors to be able to prescribe DMSO without fear of censure from the medical world or the hospitals that employ them. If this doesn’t happen, it appears that little will be done to ensure that a pure, medical grade of DMSO will be made available for patients.

In writing this book, I have found a distinct reticence by doctors to have their names mentioned in connection with DMSO. Often they provided me with glowing case reports of successes with the drug treatment, but their fear of colleague criticism prevented my revealing their identities. I had to discard such reports, and there were hundreds of them.

DMSO has the largest potential number of uses ever documented for a single chemical. My wish is that this book will bring more of them into the public domain than has been allowed to this point. It should be well understood by everyone at the outset that I don’t say the substance is some kind of miracle cure. More properly, DMSO is a very effective and versatile compound that has been successfully adapted for a number of health problems. I want to get it into the hands of more people so that they may be relieved of discomforts and diseases for which DMSO is appropriate. I hope you will agree that mine is a worthy goal.

Morton Walker, D.P.M.

Stamford, Connecticut

CHAPTER 1 – The Painkiller with a Problem

In the late spring of 1980, Eva Lee Snead, M.D., then a family practice specialist in San Antonio, Texas, learned that her friend, thirty-two-year-old psychologist Marjorie Saloman, was supposed to undergo a hysterectomy, the removal of her uterus. Mrs. Saloman’s genital system problem arose from a stenosis of the cervical os. This condition is a narrowing or stricture at the mouth of the neck-like opening to the uterus where it extends into the vagina.

The psychologist described to Dr. Snead how several unsuccessful attempts at cervical dilatation had been attempted by her gynecologist. He tried to relax the cervix by injecting local anesthesia at its lower quadrant. Such an anesthetic technique usually is simple and effective, but this particular block had been no help to the woman even after many tries. Mrs. Saloman’s gynecologist admitted that for her the attempted cervical dilatation was a complete failure.

The pain had been so great for this patient that when the dilatation instrument was inserted she had fainted. Her gynecologist quickly removed the instrument because4 the anesthetic was not allaying the pain. None of his attempts to relieve the problem worked; surgical removal of the uterus was the next procedure of choice.

Dr. Snead asked her friend to wait a week before having the hysterectomy, if delay was agreeable to the gynecologist. Complying with this request, Marjorie Salomon had her physician telephone Dr. Snead to learn the medical reasoning behind it.

Having some prior experiences with DMSO (dimethyl sulfoxide) treatment, Dr. Snead persuaded him to combine the substance with vitamin E and apply it topically to the patient’s cervical area. Dr. Snead wanted to try to reduce the woman’s scar tissue and adhesions, which DMSO is able to do.

“I was lucky enough to run into the gynecologist on the day that we were going to apply the DMSO,” Dr. Snead wrote me, “and he inserted the substance himself with the vitamin E. Before five minutes were over, his instrument slipped into the cervix without any sensation felt by the patient.”

A month later, the gynecologist rechecked the woman’s constricted cervix and found it was still overly narrow. He repeated the application of DMSO and vitamin E and after a few minutes was able to insert eh instrument to stretch the opening without any problem. This time it was a highly successful procedure, and the hospital appointment for surgery was cancelled.

The patient wore a device that was inserted to keep the cervical canal’s wall stretched. In the meantime, Dr. Snead placed her friend on megavitamin therapy using high doses of nutrient substances to restore health to surrounding tissues.

One month after the device had been inserted; the woman was again checked by her gynecologist who found the cervical ok perfectly expanded. He was able to insert probes without first applying DMSO or anesthesia and without the patient feeling any discomfort. Marjorie Saloman had definitely been saved from having a hysterectomy.

Yet Dr. Eva Lee Snead had her medical license revoked for repeatedly employing DMSO and other forms of complementary medicine – what some have labeled “quackery” but that rightly may be considered alternative methods of healing. The state of Texas is not predisposed to allowing deviations form the medical mainstream. And, as you will see, use of dimethyl sulfoxide by forward-looking physicians is out of the medical mainstream.

Lorae Avery, Ph.D., director of The Health Center, Inc., an acupuncture and nutrition clinic in Auburndale, Florida, expressed her amazement to me at the effectiveness of DMSO in eliminating pain. She saw excellent results when physicians working for The Health Center applied the substance externally to patient. One of them was sixty-five-year-old Anna Goldeman, who had been suffering for years with bursitis of the right shoulder. She went to The Health Center for relief of the bursitis in November, 1980, and was gratified by the results of DMSO treatment.

More dramatic than the patient’s alleviation of her shoulder pain was the easing of a discomfort that had begun four years previously. Mrs. Goldeman had undergone amputation of the left hip high in the groin, which resulted in “phantom limb pain.” After amputation of a limb, or a portion of it, the amputee may experience strange sensations as though the part were still there. This feeling of phantom pain is generally considered to be a stump hallucination. It arises from various types of nerve stimuli, resulting in burning, tingling, pricking, tickling, or really severe pain. Such sensations are not uncommon for an amputee and are not readily treatable.

With application of DMSO to her right shoulder, phantom limb pain with its constant twitching went out of Mrs. Goldeman’s left groin. She no longer sensed that she still had an extremity. Now she could feel more at peace with her situation.

Dr. Avery said, “We did not attempt to treat the phantom limb pain; our physicians were concerned with the bursitis. Yet, the phantom pain disappeared coincidentally from application of DMSO to the woman’s shoulder. Thus, what happened is, DMSO applied to one part of the body caused phantom pain to go away in another part of the body. And it’s permanently stayed away.”

Checking back with Dr. Avery over ten years later, I learned that Mrs. Goldeman continues in comfort knowing that DMSO is available to cease her pain whenever needed.

Murray Franklin, M.D., of Chicago, is a Clinical Associate Professor of Medicine at the University of Illinois College of Medicine, as well as the medical director of the Union Health Service, the largest pre=paid medical plan in the state of Illinois. He received a supply of DMSO in the fall of 1980 and decided to try it for the benefit of some patients for whom nothing else had worked. One of the people receiving topical therapeutic applications was Lucas Sheinholtz, fifty-two, who had been troubled with rheumatoid-osteoarthritis of both knees for more than a decade. Mr. Scheinholtz, hobbling with the assistance of two canes, arrived at Dr. Franklin’s office complex to visit another physician. The patient had previously received many injections of cortisone, which his regular physician administered routinely. But no appreciable improvement in his arthritis had been observed by either the patient or his doctor.

“I suggested to the man’s physician that we might paint some DMSO on both of his painful knees,” Dr. Frankin said. “His right knee was swollen; the left knee was not. The right knee was warm to the touch. The patient’s doctor agreed to a therapeutic trial, and I applied DMSO in three applications. Since I was not fully acquainted with how to use the solution, I allowed an application to dry and then put in on again and again. Within fifteen to twenty minutes the patient said he felt no pain and was able to walk practically without the use of a cane.

“He returned in one week and described his pain the left knee as having disappeared completely,” said Dr. Franklin. “There just wasn’t any. The pain in the swollen right knee had returned just a little. I applied the DMSO again and the man got a similar result within a quarter of an hour. No more pain! I haven’t seen him since and presume he is feeling fine.”

THE NEW MEDICAL BREAKTHOUGH FOR PAIN

The people have a new medical breakthrough for pain: dimethyl sulfoxide, called DMSO. By itself or in combination with other medical ingredients, dimethyl sulfoxide should be useful in treating almost every disease known to mankind. The substance, a byproduct of pulp and paper manufacturing, has been employed safely and successfully by millions of people around the world to control swelling; reduce discomfort; take away inflammation; slow the growth of, and in many instances kill, bacteria, viruses, and fungi. It heals burns and relieves sprains, strains, and arthritic joints. It has worked effectively against cataracts, sports injuries, scleroderma, myasthenia gravis, tuberculosis, and even lessened mental retardation in people with Down’s syndrome.

Cancer seems to respond well to DMSO. At Mount Sinai Hospital in New York City, Charlotte Friend, M.D. has turned cancerous cells into harmless normal ones in the test tube by putting them in touch with the DMSO solutions. Thus, DMSO cancer research is in progress.

Reported in the Journal of Clinical Oncology, in November 1988, twenty cancer patients with extravasations of anthracycline (destructive secretions from tissues of the toxic chemotherapeutic agent anthracycline onto the recipient’s skin with the potential to form cancerous ulcers) were treated on a single-arm pilot study with topical-applied 99 percent dimethyl sulfoxide and observed for three months with regular examinations and photographs. DMSO was applied to approximately twice the area affected by the extravasations and allowed to air dry. This was repeated every six hours for fourteen days. The initial signs of extravasations included swelling, redness, and pain. The median area of damage on the skin of these patients was 8.25 square centimeters (cm2) and a median of twenty-five minutes elapsed between extravasations and application of DMSO.

In no patient did extravasation progress to ulceration or require surgical intervention, as is usual with this toxic chemotherapeutic agent for cancer. The authors of this report suggest with 95 percent confidence that ulceration was likely to have occurred in at least 17 percent of these patients. They go on to say that at three months there was no sign of residual damage in half the patients, while a pigmented indurate area remained in ten. The only side effects of DMSO included a burning feeling on supplications, subsequently associated with itch, redness, and mild scaling. Slight blisters occurred in four patients, and six reported a characteristic breath odor associated with oysters. The oncologists stated that topical DMSO appears to be a safe and effective treatment for the cancer-related condition, anthracycline extravasation.

DMSO tends to prevent the formation of scar tissue, or to dissolve it once present. The contracture (drawing together) of scar tissue ordinarily left after a burn doesn’t take place.

Chilean physicians have published their results of using the substance, which indicate that it reduces the incidence of heart attacks or angina pain. It has been credited with preventing damage to heart muscle when tested in animal experiments. As with its use in stroke, DMSO may be lifesaving if employed early in heart attacks. Investigation is continuing.

Studies in Chile also show DMSO to be a penetrate across the blood-brain barrier. It carries drugs effective against certain forms of mental illness directly into the brain.

Placed into the nostrils, DMSO can open blocked sinuses with a few minutes.

It transports antibiotics right into the middle war to lessen infections. It does the same against viruses and reduces the symptoms of herpes zoster (shingles) and herpes simplex (fever blisters). The viruses are hit with antiviral drugs by the DMSO transport. Furthermore, the herpes II venereal disease is greatly relieved by application of DMSO directly to the genitalia.

Periodontitis in Poland have cleared up gum disease and reduced tooth decay and their associated pain by painting DMSO on the involved areas. Some pioneering dentists are dropping it into empty tooth sockets after extractions, especially those for wisdom teeth. It stops post-extraction swelling.

A 1987 paper coming out of Russia described the treatment of patients having generalized Periodontitis with indomethacin in a suspension of dimethyl sulfoxide. Periodontitis is disease of the structures su7pporting the teeth such as the gums, periodontal membrane and alveolar bone. The action of bacteria on food debris accumulated around the margins of the gums causes the formation of plaque, which eventually forms a hard deposit, tarter (or calculus). This accumulates in the gingival crevices (the spaces between the gums and the surface of the teeth), which become abnormally enlarged to form gingival pockets. It’s an early stage of periodontal disease.

In chronic gingivitis, the gums are marked by chronic inflammation, and they become swollen and bleed easily. Calculus accumulates in the gingival pockets, causing bleeding and ulceration. Untreated, the plaque spreads to the underlying periodontal membrane and alveolar bone, which are destroyed. In this stage of chronic Periodontitis, the teeth become loosened and eventually fall out.

Periodontal disease is the major cause of tooth loss in middle-aged and elderly people. It is brought on by poor oral hygiene and also by ill-fitting dentures and badly made artificial crowns and fillings. The early stages of Periodontitis are treated by scaling to remove the calculus and polishing to remove the plaque, combined with careful oral hygiene. In advanced disease the gingival pockets are surgically removed by gingivectomy (gum excision).

Now periodontal disease is being treated with indomethacin and DMSO, in combination. Indomethacin is a drug with anti-inflammatory, anti-fever, and pain-killing properties, but containing no corticosteroids. Its mode of action, like that of certain other anti-inflammatory drugs, is not known.[1]

Before this Russian publication, clinical results from the treatment of a hemorrhagic form of Periodontitis were reported from Bulgaria. The clinicians used a complex herb extract and 15 percent DMSO to rid their patients of periodontal disease.[2]

American podiatrists have found DMSO effective for the treatment of painful corns, calluses, ingrown toenails, bunions, hammertoes, heel spurs, and even the inflammation of gouty big toes. DMSO appears to control gout pain after just seven days of application.

All this happens in a way that medical scientists have yet to fully understand. They don’t know how DMSO actually works. For this reason primarily, DMSO is not approved by the United States Food and Drug Administration (FDA) for any other human medicinal use except as a treatment for interstitial cystitis, a condition that causes scarring and gradual shrinkage of the bladder.

Bruce H. Stewart, M.D., of the University of Alabama, administered DMSO to 213 patients and found it quickly healed the bladder condition despite the fact that the patients had not responded to traditional treatment. Before the success of DMSO, people suffering with interstitial cystitis faced either major surgery of the bladder, or even its complete removal. They suffered from the urge to urinate as frequently as every ten minutes.

Unlike criteria laid down for studying the use of DMSO for other conditions, the study on interstitial cystitis was done following an elementary protocol. The patients were ill, didn’t improve spontaneously, and all forms of treatment were ineffective. They then received DMSO and improved markedly. DMSO had eliminated the patients’ health problems and won approval by the FDA for use in bladder treatment – but only for interstitial cystitis.

THE FDA OBJECTION TO OTHER DMSO USES

“The fundamental problem from the point of view of the FDA is the quality of the scientific information that is available to support the various claims that are made for DMSO,” said J. Richard Crout, M.D., Director of the Bureau of Drugs with the Food and Drug Administration. Dr. Crout made his statement at a hearing before the House Select Committee on Aging, 96th Congress, held March 24, 1980.

Dr. Crout continued, “I want to make it clear that the Food and Drug Administration has approved DMSO for the indication for which there is evidence that meets the statutory standard. We are prepared to approve it for any other indications when the evidence comes along that it does meet that statutory standard.”

In brief, the drug can be approved if clinical researchers show substantial evidence of its effectiveness by providing the FDA with well-controlled trials. The “possibility” that DMSO is effective, according to the present statute, is simply not enough. For this reason, the only thing holding up FDA approval of DMSO for any of the substance’s indications is the availability of well-controlled trials that meet statutory standards, said Dr. Crout. There is a basic conflict between the quality of the scientific evidence available and the statutory standard for approval.

This fundamental confrontation is best illustrated by a new drug application (NDA) submitted in 1978 by Research Industries Corporation of Salt Lake City, Utah, the major producer of a human medicinal grade of DMSO in 50 percent concentration Rimso-50. Research Industries Corporation wanted to extend the use of its product and market it for the symptomatic relief of pain and ulceration in the finders of patients with scleroderma. Scleroderma is a rare collagen disorder that results in thickening of the skin from the swelling of fibrous tissue. It most often involves the hands, especially causing ulcers on the fingers, and less frequently on other tissues in the body. After detailed review by the FDA’s Bureau of Drugs staff and its Arthritis Advisory Committee, the NDA was refused on the grounds that the available clinical trials did not yet demonstrate that DMSO was effective for scleroderma. Medical science’s current investigative techniques using double- or single-blind studies seemed inadequate for evaluating the effectiveness of DMSO in this instance.

Research Industries Corporation relied principally on one particular study to demonstrate DSMO’s effectiveness against scleroderma. This study had each patient dip only one hand into a solution of DMSO. The untreated hand was observed as a control. Both hands had ulcerations of the skin of the fingers, and investigators thought that DMSO’s effectiveness in healing sclerodermatous ulcers would clearly be shown by what happened to the two hands.

Dr. Crout described what happened. “There was a general improvement trend in the healing of ulcers of the fingers in many patients, and in a few this was quite striking. Interestingly, however, this improvement occurred in both hands in these patients with scleroderma; that is, both the treated and untreated hands tended to heal.”

Now, DMSO is different from any other known medical substance in that it is easily absorbed into the body. Paint an amount the size of a silver dollar anywhere on your upper body and in thirty seconds you’ll taste it on the tip of your tongue. It penetrates the skin and travels through the blood stream that fast.

The officials of the Research Industries Corporation argued that both hands of the affected patients healed because DMSO worked equally well on the hand in touch with the liquid and on the control hand. Simply, DMSO healed the control hand by traveling through the blood stream to the ulcer site. Absorption of the substance into the body from the treated hand was inevitable because of its unique power of penetrability. Current techniques utilizing the scientific method as it is understood today cannot be applied to the study of DMSO.

Dr. Crout said, “Our staff and advisory committee felt, to the contrary, that improvement of the untreated hand raised the strong possibility that the general improvement trend in the whole trial was attributable to a nonspecific effect of DMSO. Everyone agreed that the trial showed that DMSO may be effective, but few felt that the trial proved the point.

“Because the statutory standard for approval of a drug is substantial evidence of effectiveness as shown by well-controlled trials, not simply the possibility of effectiveness,” continued the FDA chief, “we are unable to approve DMSO for this indication at this time.”

In order for a new drug to be recognized by the FDA it must conform to section 505 of the Food, Drug, and Cosmetic Act, which holds that the standard for effectiveness is “substantial evidence” of effectiveness. This means evidence must come from controlled clinical investigations conducted by experts qualified by scientific training and experience to evaluate the effectiveness of drugs.

Dr. Crout declared that applications for an investigational new drug (IND) submitted for DMSO during the previous eighteen years were faulty. They had not been assembled into scientifically designed studies. They had not followed that certain discipline required by research. All INDs must go through a standard FDA procedure to win approval. The prior investigational new drug applications submitted by three pharmaceutical companies of national repute were poorly prepared, said Dr. Crout, and the companies did not know how to present an IND application to the FDA to show proper evidence of value in the use of DMSO. He made this statement despite the fact that these same pharmaceutical firms had previously won approval for other drugs.

FLAWS IN FDA PROCEDURE

Of course, the pharmaceutical companies disagreed. The co discoverer of the therapeutic properties of DMSO, Stanley W. Jacob, M.D., Associate Professor of Surgery at the University of Oregon Medical School, certainly disagreed. He believed the advisory committee that made recommendations against FDA approval of DMSO was biased against DMSO. Dr. Jacob told the House Committee of Aging: “I am not at all satisfied that the FDA is giving DMSO a fair shake.”

The DMSO researchers who worked with patients on a case-by-case basis pointed out that the FDA advisory committee was negatively disposed. The committee members had never themselves used DMSO as a therapeutic tool. And this was admitted by Dr. Crout.

The Honorable Claude Pepper, former Chairman of the House Select Committee on Aging, was inclined to agree with the analysis made by Dr. Jacob. Congressman Pepper told Dr. Crout, “If there is a drug that was being pressed upon you by three drug companies who apparently thought the drug had enormous potential, in a case like that, I would think that you would be eager to see if the claims that were made could be justified. You would be looking for a satisfactory proof that would square with your conscience and your judgment that that product might give relief to a lot of people and could be put on the market.

“Now, the public – and I must say up to now I share the opinion – has the impression that your agency in its desire to be careful and its desire not to let anybody be hurt, has denied perhaps a lot of people relief in fear that if they allowed the thing to be approved as it was being presented, that they might be hurt by it; that yours is a negative attitude, that you don’t tell them what is wrong with the application in an informal way so they can attempt to correct it and the like; that you are not eager to see the users of the country that might profit from it get the advantage of it,” said the Congressman.

“You say, ‘It is no skin off my back,’ as the old saying goes, ‘if these folks cannot comply with the technicalities. That is the law; it is none of our responsibility. Let them get a better lawyer or somebody else. We are not running it. We are just sitting up here trying to protect the public interest.’

“Are you sure that there is no justification for the public or even members of Congress having that impression of our regard of your duties?” asked Congressman Pepper. “Are you sure there is no foundation for that fear?”

Dr. Crout discounted such a possibility and implied that DMSO was having difficulties because it was so unorthodox. He said it would be far easier for a new drug to have its application approved if it was closer to something already in the marketplace, such as a new antibiotic or tranquilizer that duplicates an existing one.

DMSO is a substance totally strange to medical science. It has a novel mode of action not understood within the context of our current healing concepts. It is an altogether new principle that will possible revolutionize therapeutics once it is studies in a more exacting way. For now, however, DMSO is not being studied in accordance with the standard double- or single-blind procedures commonly used in the scientific method. This is the present problem. And it is one that has perplexed the medical community ever since DMSO was first discovered to have therapeutic value to counter human injury and heal human disease.

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The existence of this new anti-inflammatory painkiller raises the questions: How can it be established with certainty the degree to which DMSO does or does not work for the numerous and varied conditions reported in the medical literature by clinicians using it successfully? Are we able to break the logjam that enables a federal agency to keep this drug from general use because its research studies don't conform to the regulations laid down by that same federal government for its citizen's protection? Does DMSO have a history of controversy among pioneering health professionals and bureaucratic medical conservatives alike, because neither group truly comprehends how radically this substance departs from know principles of healing? Must DMSO remain controversial?

CHAPTER 2 – DMSO's Controversial History

On November 10, 1980, United Sates Food and Drug Administration officials entered the office of Dr. Stanley Jacob at the University of Oregon Health Sciences Center. They were looking for research reports on possible damage to human eyes from the use of DMSO. They had an administrative search warrant issued by a federal judge and were prepared to rifle through and seize the files kept by Dr. Jacob.

William Zuber and Dr. Alan B. Lisook of the FDA were refused access to any documents by Jacob even in the face of the federal warrant. Instead, Jacob's attorney, Jay Geller, answered the warrant point-by-point in federal court. Mr. Geller said such reports or documents didn't exist or, if they did, were not in Jacob's possession .

Geller added that certain documents requested were privileged patient information and not available even under court order except in cases where patients give permission. Zuber and Lisook walked away with only one paper that Jacob provided a two-page memo on DMSO and its legal use in treating interstitial cystitis. Otherwise, they got no response to questions they asked. Zuber admitted he did not have any authority to question the physician, since the Food, Drug, and Cosmetic Act does not give the FDA "access to people, just things."

When Lisook asked Geller whether the reports had ever been in Jacob's possession in the past, Geller assured the investigators that they had not and that no documents had been removed from the doctor's office since the warrant was issued. Zuber and Lisook then terminated the meeting, saying they didn't believe they could obtain any information "central to this warrant."

Geller accused the FDA of harassing Jacob. He said much of the information requested in this federal warrant was on record from previous hearings.

Jacob said there was no evidence of damage to the human eye caused by DMSO. "Allegations of hidden toxicity are false," he stated.[3]

Such controversy, with legal actions and reactions, has commonly surrounded the puzzling painkiller dimethyl sulfoxide. Its exciting biological and medical uses have made the substance one of the stormiest and most disputed drugs of our day. It lay dormant for nearly one hundred years after its discovery; now it had burst on the medical scene amidst contention, discord, charges and countercharges – literally a war intended to convince others of the truth.

The loser in all this intraprofessional argument is the medical consumer. Patient advocacy doesn't seem to exist when it relates to DMSO. Welfare for the people has been abandoned. The facts remain undetermined with certainty; guidance to help victims of illness made the wisest health decisions for themselves has been ignored. Health professionals and medical bureaucrats apparently are failing to fulfill their responsibilities to the public.

THE SOURCE AND ORIGIN OF DIMETHYL SULFOXIDE

DMSO was first synthesized in 1866 by Russian scientist Alexander Saytzeff in Kazan, on the Volga River in Central Russia. He saw that the substance was colorless, had a garlic-like odor, felt oily to the touch, looked like mineral oil when poured from the test tube, and left an aftertaste similar to clams oysters. It had laboratory curiosity value for Dr. Saytzeff and his fellow chemists because dimethyl sulfoxide combined with almost any chemical he dropped into the liquid. It was an excellent solvent, useful as a degreaser, paint thinner, and antifreeze. For about eighty years, the only publication advising scientists about the stuff was a paper Dr. Saytzeff had submitted to an obscure German chemistry journal that printed his article in 1867.

After World War II, chemists started to show active interest in the substance. A number of papers appeared in chemical literature in 1948, showing DMSO to be an excellent solvent. In 1959, a group in Great Britain demonstrated that the solvent would protect red blood cells and other tissues against freezing conditions.

Dr. H. Harry Sczmant, Chairman of the University of Detroit's chemistry department, explained that the liquid has a tremendous capacity to dissolve substances. It is a reagent that can speed up some chemical reactions a "billion fold."

"The unique capability of DMSO to penetrate living tissues without causing significant damage is most probably related to its relatively polar nature, its capacity to accept hydrogen bonds, and its relatively small and compact structure," he said. "This combination of properties results in the ability of DMSO to associate with water, proteins, carbohydrates, nucleic acid, ionic substances, and other constituents of living systems. Of foremost importance to our understanding of the possible functions of DMSO in biological systems is its ability to replace some of the water molecules associated with the cellular constituents, or to affect the structure of the omnipresent water."[4]

Controversy began to surround DMSO in 1962 when Dr. Jacob first became interested in how to safely freeze human kidneys and considered the solvent for this purpose. He asked Robert Herschler, a chemical applications supervisor at the Crown Zellerbach Paper Company, for some of the chemical. Crown Zellerbach had plenty to spare, since DMSO is a byproduct of its paper-making process. For five dollars a quart it can be produced commercially in crude form for refining into human medicinal application.

At their first meeting, Robert Herschler mentioned that he had difficulty washing the stain off his hands when both DMSO and dye got on them. Dr. Jacob recalls: "We painted DMSO on our skin and within fifteen minutes noticed an oyster and garlic taste. The skin where the chemical had been was dry."

The drying effect of dimethyl sulfoxide set off the DMSO explosion. Dryness of a therapeutic agent makes it valuable in the treatment of burns, since moisture tends to promote infection. Jacob and Herschler tried it on burned rates and found those treated were quieter in behavior than the untreated. The drug relieved burn pain. "From that point on, DMSO usage just spread like wildfire," Dr. Jacob said in an interview.

In the United States DMSO is derived from lignin, the cement substance from trees. In Europe and other places it is synthesized from coal, petroleum, of other organic substances.

Collaborative efforts between Jacob's staff representing the University of Oregon Medical School and Herschler representing Crown Zellerbach Corporation demonstrated in laboratory tests that DMSO would not only pass through the skin and mucous membranes, but during passage would carry with it a certain number of other substances. For instance, penicillin can be dissolved in DMSO and be carried through he skin without a needle. Local anesthetic can be carried the same way.

In these early studies, DMSO was shown to relieve pain, reduce swelling, slow the growth of bacteria, improve blood supply, soften scar tissue, enhance the effectiveness of other pharmacologic agents, act as a diuretic, and function as a muscle relaxant. It eliminated the pain of sprains, strains, and arthritis, and even the pain of broken bones.

Veterinarians used the substance, by prescription, for arthritic conditions or injuries in animals. In arthritic greyhounds, k an injection of either DMSO or corticoid (a substance that has an action like a hormone of the adrenal cortex) will enable the animal to race again. In six months 60 percent of the corticoid-treated dogs will have a recurrence, but less that 20 percent of the dogs treated with DMSO show such recurrence.

THE FDA ENTERS THE PICTURE AND CONTROVERSY STARTS

The first report on the use of DMSO as a pharmacologic agent was written by Jacob in 1963 and published February 1, 1964. It caused a flood of trials and wild enthusiasm over the new "miracle" drug that carried other substances through the skin and into all organs of the body. It was soon obvious that the chemical could relieve inflammation and pain in many conditions, some heretofore untreatable any other way.

The first investigational new drug (IND) application for the clinical study of DMSO in humans was submitted to the FDA on October 25, 1963, and subsequently approved. Enormous interest in the drug developed rapidly, to the point where it began to be used very extensively, especially for the treatment of sprains, bruises, and minor burns. The drug was supplied at no charge to great numbers of investigators in general medicine, specialty medicine, and to paramedical professionals, including physiotherapists, a few dentists, nurses, and the author of this book, a former practicing podiatrist.

By 1965 an estimated 100,000 patients had received the medication. Studies were being conducted but the FDA did not consider them to be well enough controlled to document clearly that the observed benefits were actually due to the drug. The New York Times, in a lead editorial on April 3, 1965, called DMSO "the closest thing to a wonder drug produced in the 1960s." An international symposium of medical scientists in Berlin, West Germany, in July 1965, was held to exchange information on the effects of DMSO.

Still, when three new drug applications (NDAs) on DMSO were submitted to the FDA in 1965, all three were turned down. The pharmaceutical companies Merck, Syntex, and Gibb submitted their NDAs with the statement that DMSO was ready to be a prescriptive agent. The FDA denied their statement and applications, and in fact published its own statement in the Federal Register terminating all clinical use of DMSO. The agency cited toxicological studies showing that high doses of the drug changed the refractive index of the eye lens in experimental animals. That is, a change occurred in their focusing power and a certain cloudiness came over the lenses.

The agency's concern was that visual damage might occur in humans exposed to DMSO. Researchers and bureaucrats didn't know at that time that the eye changes were limited to particular species. Nothing happens to monkeys or, most important, to human beings.

A year later this prohibitive policy was relaxed somewhat. The FDA permitted new investigations for the clinical evaluation of DMSO in serious conditions, such as scleroderma, persistent herpes zoster, and serious conditions, such as scleroderma, persistent herpes zoster, and severe rheumatoid arthritis, for which no satisfactory therapy is available.

In September 1968 the FDA published a further revision, a relaxation of its DMSO policy that allowed topical application to the skin for not more than fourteen days for less serious disabilities such as acute musculoskeletal conditions – for example, sprains, bursitis, and tendinitis. This relaxation of rules was based on a toxicological study of people that provided a reassuring result: no evidence of human eye toxicity due to DMSO was present.

[1] Babenko, V.N. "Treatment of patients with generalized periodontits with a suspension of indomethacin in a dimexide solution." Stomatologiia (Mar./Apr. 1987); 66(2):26-28.

[2] Goranov, K.; V. Zarankova; M. Velceva; and S. Dermend: zieva. "Clinical results from the treatment of a hemorrhagic form of periodontosis with a complex herb extract and 15 percent DMSO." Stomatologiia (Nov./Dec/ 1982); 65(6):25-30.

[3] "DMSO Documents Sought," NHF Public Scrutiny. Vol. XXVII, No. 27, January, 1981, p. 29.

[4] Szmant, H. Harry. "Physical properties of dimethyl sulfoxide and tis function in biological systems," Biological Actions of Dimethyl Sulfoxide, Stanley W. Jacob and Robert Herschler (eds.), New York: Annals of the New York Academy of Science, Vol. 243, January 27, 1975, pp. 20-23.

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